VERY IMPORTANT INFORMATION

- **Plan to arrive at the Sleep Lab at the time specified in the enclosed letter.**
- **Complete** the forms in this packet and bring them with you the night of your study.
- If you need to take any medications before bedtime, bring them with you (this includes something as basic as aspirin or Tylenol). **Medications CANNOT be provided to you by the sleep center.**
- Have your hair clean and dry the day of your test.
- Do not wear makeup or use any products in your hair. Do not apply any heavy creams or lotions to your skin because they alter the quality of your test.
- Bring something to sleep in that is 2-piece and loose fitting.
- Bring your insurance card and a photo id (drivers license).
- Go about your normal day; this includes performing all your usual activities and taking all of your usual medications.
- Try to **avoid**:
  - Naps unless they are a usual part of your day. If you do nap, make it slightly shorter than usual.
  - Excessive amounts of caffeine, more than normal (coffee, tea or cola beverages).
- If you have special needs (i.e. hospital bed, bedside commode, oxygen, nebulizer, etc.) and you have not already advised your scheduler, call 962-5710 prior to your appointment (Mon – Fri, between the hours of 8:00 am – 4:30 pm). In some cases, it may be necessary for you to bring your equipment from home.
- If you have not yet spoken to the pre-registration department, call the number listed on the letter at the front of this packet for pre-registration.

COMMON QUESTIONS REGARDING SLEEP TESTING

What symptoms might lead my doctor to suspect I have a sleep disorder?
Some symptoms include excessive daytime sleepiness, fatigue, depression, insomnia, hypertension, morning headaches, poor concentration and memory loss. Perhaps your bed partner has complaints of loud snoring/snorting, teeth grinding, active leg/body movements during sleep and many others.

What is a sleep test?
The technician assigned to you will apply various monitors to your head, chest, legs, finger, nose, mouth and throat. These specialized devices will record the details of your sleep and tell the doctor about the quality of sleep you are getting, oxygen level, heart rhythm, breathing pattern and various other things occurring while you sleep.

How long does this test take?
In order to obtain an accurate account of all the complicated functions of sleep, you are expected to stay for six to eight hours the night of your test. It will take the technician approximately 45 minutes to apply the recording devices and approximately 15 minutes to calibrate the devices to you. During the calibration, you will follow verbal commands given by the technician.

What if I need something or have to go to the restroom in the middle of the night?
Once you are connected to the testing equipment, you can move freely in bed. If you need to leave the bed for any reason, state your request out loud and a technician will be there promptly to assist you.

What is CPAP? What does CPAP do?
CPAP stands for Continuous Positive Airway Pressure. It is a small bedside unit that has tubing and a small mask that is placed gently over your nose and delivers air into your airway. It merely assists your body in breathing while allowing you to rest so that the breathing irregularity does not keep you from sleeping properly. If the technician observes a breathing problem during your study, he/she may awaken you to continue the test with one of these devices.

Will there be TV and DVD available in the room?
Each room has a TV and a DVD player; however, at some point in the evening the technician will ask that you attempt to fall asleep without the TV on for clinical reasons.

Will I have to pay for parking?
No, you will be leaving when there is no parking attendant or the lab will give you a parking pass in the event you leave later in the day.

Will I be able to have a family member stay with me?
No, we do not have additional rooms for family to stay. If a caregiver is required, the caregiver is to stay in the room monitoring the patient.

Do you have refrigerators for food and/or medication?
Yes, we have a medication refrigerator and a separate food refrigerator.

PLEASE DO NOT ARRIVE MORE THAN 15 MINUTES PRIOR TO YOUR APPOINTMENT TIME.

SLEEP DISORDERS CENTER

PATIENT INFORMATION
(Page 1 of 1)

FOR OFFICE USE ONLY:

Sleep MD: _____

Date: _____ Sex: **Male** **Female**

Name: _____
Last First MI

Address: _____ c/o _____
Street Address City State Zip

Home Phone: (____)_____ Work: (____)_____ Other: (____)_____

Date of Birth: _____ Cell: (____)_____

Primary Care Doctor: _____ Phone: (____)_____

Address: _____
Street Address City State Zip

Patient's Employer: _____

Address: _____
Street Address City State Zip

Patient's Spouse: _____
Last First MI

Spouse's Employer: _____ Phone: (____)_____

Address: _____
Street Address City State Zip

EMERGENCY CONTACT NOT RESIDING WITH PATIENT:

Name: _____
Last First MI

Address: _____
Street Address City State Zip

Home Phone: (____)_____ Work Phone: (____)_____

☐ Spiritual/Cultural implications that impact care

Spiritual Resource: _____ Phone: (____)_____

INSURANCE INFORMATION BELOW MUST BE FILLED OUT <u>COMPLETELY</u>

<u>Primary Insurance:</u> _____ Phone: (____)_____

Subscriber's Name: _____ SS#: _____ DOB: _____

Insurance Address: _____

Policy/ID#: _____ Group/Acct#: _____ Effective Date: _____

<u>Secondary Insurance:</u> _____ Phone: (____)_____

Subscriber's Name: _____ SS#: _____ DOB: _____

Insurance Address: _____

Policy/ID#: _____ Group/Acct#: _____ Effective Date: _____

DOES YOUR INSURANCE REQUIRE HOSPITAL PRECERTIFICATION: ☐ **Yes** ☐ **No**

PARENT/GUARDIAN INFORMATION: *(complete if patient is a child/minor)*

Parent/Guardian Name: _____

Address: _____ Home Phone: (____)_____

Employer: _____ Other Phone: (____)_____

Work Address: _____

Pt. Name _____ DOB_____

SLEEP/ MEDICAL HISTORY FORM

PATIENT INFORMATION

Height _____ Weight _____

A) CHIEF COMPLAINT - Please describe your sleep/wake problem and how long it has been present.

_____

_____

B) TYPICAL SLEEP TIMES:	**Weekdays**	**Weekends**
Go to bed:	_____	_____
Get out of bed:	_____	_____
Naps during the day:	_____	_____
Time spent asleep:	_____	_____

How many times do you awaken from sleep each night on average? _____

What do you think causes this or what do you notice at that moment? _____

C) PAST MEDICAL HISTORY - List any significant health problems in the following areas.

	Type of Problem	Dates
Allergies to medications	_____	_____
Head or nervous system or stroke	_____	_____
Eyes, ears, nose, throat or mouth	_____	_____
Upper airway allergies	_____	_____
Breathing (lungs)	_____	_____
Heart, circulation or blood pressure	_____	_____
Stomach, digestive	_____	_____
Kidney diseases	_____	_____
Anxiety or depression	_____	_____
Other medical problems (diabetes, thyroid disorder)	_____	_____
Arthritis	_____	_____

Pt. Name _____ DOB_____

D) PAIN

Origin _____Onset _____

Location _____Quality (i.e. burning, dull ache)_____

Intensity Level: 0 1 2 3 4 5 6 7 8 9 10 Frequency/Duration _____

Aggravating/Relieving Factors _____

Pain Management History _____

Present Pain Management Regimen and Effectiveness _____

Other (Specify)_____

List all prescriptions and non-prescription medicines. Use space below if necessary.

1. _____ Dose _____ times/day _____
2. _____ Dose _____ times/day _____
3. _____ Dose _____ times/day _____
4. _____ Dose _____ times/day _____
5. _____ Dose _____ times/day _____
6. _____ Dose _____ times/day _____
7. _____ Dose _____ times/day _____

Please list all medicines that you are allergic to: _____

_____

_____

_____

_____

(Use this blank space to provide additional information; please continue to complete the following pages.)

Pt. Name _____ DOB_____

The following list includes possible complaints or problems associated with <u>sleep at night</u>. Please circle the number for each complaint/problem listed. Use the following scale:

0 = never
1 = rarely (once or twice in your life)
2 = sometimes (once or twice each year)
3 = often (once or twice each month)
4 = very often (once or twice each week)
5 = always (every night)

0 1 2 3 4 5 snoring disturbs others

0 1 2 3 4 5 gasp or wake up from sleep choking

0 1 2 3 4 5 stop breathing for short periods

0 1 2 3 4 5 feel paralyzed when falling asleep or waking up

0 1 2 3 4 5 have near hallucinations or dreamlike images when falling asleep or just waking up

0 1 2 3 4 5 have leg cramps at night

0 1 2 3 4 5 uncomfortable, crawling sensation in legs that is relieved by moving or walking

0 1 2 3 4 5 jerk your arms or legs at night

0 1 2 3 4 5 sleep restlessly

0 1 2 3 4 5 have aches or pains at night Please describe:_____

0 1 2 3 4 5 have problems falling asleep or staying asleep

0 1 2 3 4 5 lie awake feeling depressed, worried, or anxious

0 1 2 3 4 5 grind your teeth at night

0 1 2 3 4 5 frightening dreams or nightmares

0 1 2 3 4 5 walk in sleep

0 1 2 3 4 5 talk in sleep

0 1 2 3 4 5 sleep often disturbed by your bed partner

0 1 2 3 4 5 sleep often disturbed by noise or pets

0 1 2 3 4 5 smoke at night

0 1 2 3 4 5 eat in bed at night

0 1 2 3 4 5 watch TV in bed

0 1 2 3 4 5 wake up with nausea or heartburn

0 1 2 3 4 5 wake up with chest pain

Pt. Name _____ DOB_____

The following list includes possible daytime complaints and problems associated with sleep. Please circle the number for each complaint/problem listed. Use the following scale:

0 = never
1 = rarely (once or twice in your life)
2 = sometimes (once or twice each year)
3 = often (once or twice each month)
4 = very often (once or twice each week)
5 = always (every night)

0 1 2 3 4 5 feel unrefreshed in the morning after sleep

0 1 2 3 4 5 find it hard to wake up in the morning

0 1 2 3 4 5 wake up with headaches

0 1 2 3 4 5 irritable

0 1 2 3 4 5 unable to concentrate

0 1 2 3 4 5 poor memory during the day

0 1 2 3 4 5 yawn frequently during the daytime

0 1 2 3 4 5 feel drowsy or sleepy during the day

0 1 2 3 4 5 daytime sleepiness interferes with normal activities

0 1 2 3 4 5 daytime fatigue

0 1 2 3 4 5 have hallucinations or dream-like mental images during the day

0 1 2 3 4 5 have attacks of sudden physical weakness or paralysis when laughing, angry, or in other emotional situations

0 1 2 3 4 5 have daytime sleep complaints that seem to go in cycles or only appear at certain times (example: only in the evenings; every 10 days; when you sleep away from home)

E) FAMILY SLEEP HISTORY - Do any of your relatives have a sleep disorder? Yes No

Circle all that apply: mother, father, brother, sister, son, daughter

Circle the type of sleep disorder: sleep apnea, narcolepsy, restless legs, insomnia

F) SOCIAL HISTORY - Please complete the following general information.

Circle whichever applies: live and sleep alone, someone sleeps in a room close by, have a roommate, married

What is your occupation _____

Cups of caffeinated coffee/day _____ Number of caffeinated drinks/day _____

Number of cigarettes, cigars or pipe-fulls of tobacco _____ /day

Number of years smoking _____

Number of alcoholic drinks per week _____

Pt. Name _____ DOB_____

G) REVIEW OF SYSTEMS - Please check those issues that apply to you.

YES	NO		YES	NO	
Ear, nose, mouth, throat:			Psychiatric issues:		
___	___	Frequent sore throat	___	___	Depression
___	___	Hay fever/allergies	___	___	Chronic Anxiety
___	___	Sinus trouble	___	___	Panic attacks
___	___	Tonsillectomy	Neurological problems:		
___	___	TMJ Syndrome	___	___	Stroke or TIA
Respiratory symptoms:			___	___	Seizure
___	___	Shortness of breath w/exertion	___	___	Neuropathy
___	___	Asthma / Emphysema	___	___	Major head injury
___	___	Chronic cough	Musculoskeletal problems:		
Cardiovascular symptoms:			___	___	Neck or back problems
___	___	Recurrent Chest pain	___	___	Arthritis
___	___	Palpitations or arrhythmia	Endocrine or gland problems:		
___	___	High Blood Pressure	___	___	Thyroid disorder
___	___	History of MI / heart attack	___	___	Heat or cold intolerance
___	___	Congestive Heart Failure (CHF)	___	___	Diabetes
Gastrointestinal symptoms:			Constitutional symptoms or issues:		
___	___	Heartburn/GERD	___	___	Poor appetite
___	___	Mononucleosis or liver disease	___	___	Weight gain over past two yrs
Kidney problems:					
___	___	Known kidney disease	_____		(How much weight?)
___	___	Kidney stones			
___	___	Prostate problems	Other_____		

If there are other physicians you would like to receive a copy of the test results, please list their names, phone numbers, and addresses here:

H) FALLS ASSESSMENT

Have you fallen 3 or more times in the last 3 months? **YES** **NO**

If you answered yes to the question above, please answer the questions below.

Were there any injuries resulting from the falls? **YES** **NO**

Was an MD informed? **YES** **NO**

Name of MD_____ Date informed_____